

December 19, 2012

Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Ave.
Washington D.C. 20201

Dear Secretary Sebelius,

Pursuant to section 3210 of the Patient Protection and Affordable Care Act (ACA) you have requested the National Association of Insurance Commissioners (NAIC) to review and revise the NAIC Medicare supplement insurance (Medigap) model regulation to include nominal cost sharing in Medigap Plans C and F to encourage the use of appropriate physicians' services under Medicare Part B. Section 3210 directs the NAIC to base these revisions on evidence published in peer-reviewed journals or current examples used by integrated delivery systems.

Consistent with the process established by the Social Security Act for changes to Medigap standards, the NAIC appointed the Medigap PPACA (B) Subgroup (Subgroup) comprised of state insurance regulators, representatives from the Centers for Medicare and Medicaid Services (CMS), insurers and trade associations, consumer advocates, and other experts in the areas of Medicare and Medigap.

The NAIC has performed its requested review of the standards for Plans C and F under Section 3210 of the ACA. We were unable to find evidence in peer-reviewed studies or managed care practices that would be the basis of nominal cost sharing designed to encourage the use of appropriate physicians' services. Therefore, our recommendation is that no nominal cost sharing be introduced to Plans C and F. We hope that you will agree with this determination.

Medigap is a product that has served our country's Medicare eligible consumers well for many years, offering them security and financial predictability with regard to their Medicare costs. Medigap's protections are now inappropriately being held responsible for encouraging the overuse of covered services and increasing costs in the Medicare program.

We do not agree with the assertion being made by some parties that Medigap is the driver of unnecessary medical care by Medicare beneficiaries. As you are aware, Medigap plans pay benefits only after Medicare has determined that the services are medically necessary and has paid benefits. Medigap cannot alter Medicare's coverage determination and the assertion that Medigap coverage causes overuse of Medicare services fails to recognize that Medigap coverage is secondary and that only Medicare determines the necessity and appropriateness of medical care utilization and services.

The statute requires the NAIC to base nominal cost sharing revisions on "peer-reviewed journals or current examples of integrated delivery systems". However, the Subgroup discovered that there is a limited amount of relevant peer-reviewed material on this topic. None of the studies provided a basis for the design of nominal cost sharing that would encourage the use of appropriate physicians' services. Many of the studies caution that added cost sharing would result in delayed treatments that could increase Medicare program costs later (e.g., increased expenditures for emergency room visits and hospitalizations) and result in adverse health outcomes for vulnerable

populations (i.e., elderly, chronically ill and low-income). Most of the studies do not consider the same population of health insurance beneficiaries as those that purchase Medigap products.

The Subgroup also gathered information from integrated delivery systems (Medicare Advantage plans) but concluded that, because these managed care plans make medical necessity determinations for Medicare, any such practices were not directly relevant for Medigap.

Also, as you know, significant new changes to Medigap plan offerings were implemented recently in 2010 which introduced new plans with increased beneficiary cost sharing. Plan M, which requires 50% beneficiary cost sharing on the Medicare Part A deductible, and Plan N, which requires a \$20 copay for physician office visits and a \$50 copay on emergency room visits, were introduced. We are still learning the impact of these new offerings on both the Medigap market and to the Medicare program.

Therefore, we hope you will agree with our recommendation that no changes should be made to Plans C and F at this time. However, we recognize that you may find that the addition of nominal cost sharing is necessary to implement Section 3210. If that is your decision, please know that the Medigap PPACA (B) Subgroup conducted extensive work in this area and voted on possible areas for revision that should serve as the basis for any further work on the issue, pending your determination on the need for additional action. The findings and work products of the Subgroup, which have not been adopted through the full NAIC process, are publicly available on their web page.

As always, the NAIC stands ready to continue its regulatory role in developing Medicare supplement standards and to assist you in any way possible.

Respectfully submitted,



Kevin M. McCarty
NAIC President
Florida Insurance Commissioner



James J. Donelon
NAIC President-Elect
Louisiana Insurance Commissioner



Adam Hamm
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Monica J. Lindeen
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Montana Commissioner of Securities & Insurance



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